

Registration District No. **317**

Primary Registration District No. **6076**

96
0
1

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **ST. LOUIS**

(b) City or town **LEMAU**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
MOUNT ST. ROSE SANITARIUM
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 WEEK**
(Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **0000**

(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")

(d) Street No. **5929 WATERMAN AVE.**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **JOHN F. CASEY**

3. (b) If veteran, name war _____

3. (c) Social Security No. **488-18-0472**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **SEPT.** day **24**
year **1943** hour **11** minute **20** P. M.

4. Sex **MALE**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **CATHERINE CASEY**

6. (c) Age of husband or wife if alive **69** years

7. Birth date of deceased **JAN. 26 1867**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 1 1943** to **Sept 24 1943**
that I last saw him alive on **Sept 22 1943**
and that death occurred on the date and hour stated above.

8. AGE: Years **76** Months **7** Days **28**
If less than one day _____ hr. _____ min.

Immediate cause of death **Pulmonary tuberculosis** Duration **1 mo.**

9. Birthplace **ST. LOUIS MO.**
(City, town, or county) (State or foreign country)

Due to _____

Due to **13 ft**

Other conditions _____
(Include pregnancy within 3 months of death)

10. Usual occupation **ENGINEER SPRINKLING BUREAU INSPECTION OF MO.**

PHYSICIAN _____

Major findings: **no operation**

Of operations _____

Of autopsy **no autopsy**

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name **MICHAEL CASEY**

13. Birthplace **IRELAND 4**
(City, town, or county) (State or foreign country)

14. Maiden name **MARY O'NEILL**

15. Birthplace **IRELAND 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS. CATHERINE CASEY**

(b) Address **5929 WATERMAN AVE.**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

17. (a) **BURIAL** (b) Date thereof **9-28-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY CEMETERY**

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature **Wm. J. Langley Jr.** (M.D. or other) _____
Address **5863 Plymouth St.** Date signed **Sept 25/43**

18. (a) Signature of funeral director **Arthur J. Donnelly**

(b) Address **3840 Lindell Blvd.**

19. (a) **SEP 28 1943** (b) _____
(Date received local registrar) (Registrar's signature)

MAR 2 2 1924

6-7

St. Hampton

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed W H Van Matre

Licensed Embalmer No. 2825

P. O. Address. 4340 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.